Department of Veterans Affairs **VHA DIRECTIVE 2006-017**
Veterans Health Administration
Washington, DC 20420 **April 3, 2006**

THE ROLE OF VHA POINTS OF CONTACT AND CASE MANAGERS TO COORDINATE CARE FOR RETURNING COMBAT SERVICE MEMBERS AND VETERANS

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy regarding the Department of Veterans Affairs (VA) collaboration with Department of Defense (DOD) to seamlessly transition the health care of injured and ill returning combat active duty service members and veterans from DOD to the VA health care system. ***NOTE:*** *This includes active duty service members and veterans directly referred from Military Treatment Facilities (MTFs), as well as outpatient active duty service members and veterans who present to VA medical centers seeking health care.*

2. BACKGROUND

a. VA is collaborating with DOD and their MTFs to seamlessly transition the health care of injured or ill returning combat active duty service members and veterans from the MTF to a VHA facility. VHA has assigned part-time and full-time social workers to major MTFs to serve as VHA liaisons between the MTF and VHA facilities (see Att. A for list of sites). Each VHA facility has selected a Point of Contact (POC) who works closely with the VA-DOD Social Work Liaisons detailed to MTFs and the Veterans Benefits Administration (VBA) representatives to ensure a seamless transition and transfer of care. While this initiative pertains primarily to military personnel returning from Iraq and Afghanistan having served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), it also includes active duty military personnel returning from other combat theater assignments. It does not include active duty military personnel who are serving in non-combat theaters of operation.

b. Veterans who have served on active duty in a theater of combat operations (as determined by the Secretary of Veterans Affairs in consultation with DOD) during a period of war after the Persian Gulf War, or in combat against a hostile force during periods of hostility after November 11, 1998, are eligible for hospital care and medical service for any illness potentially related to their service in the combat theater for a 2-year period following separation from military service. During this 2-year post-discharge period, they are not subject to medical care and medication co-payments when their physical or mental condition is determined by their health care provider to be potentially related to their exposure or military experience, regardless of income (known as enhanced combat veteran benefits). Those veterans who did not serve in a combat theater are subject to the same eligibility requirements as all other veterans. ***NOTE:*** *Reference VHA Directive 2005-020, Determining Combat Veteran Eligibility, for further details.*

c. Members of the Reserve Component (National Guard and Reserve) are eligible for VA health care if they were called or ordered to active duty by a Federal declaration, served the period to which they were called and have separated from active military service under other

than dishonorable conditions. National Guard and Reserve members who were mobilized to active duty, served in a combat theater, and separated from active duty receive a DD 214, Certificate of Release or Discharge from Active Duty; they are eligible for VA health care and benefits including the enhanced combat veteran benefits.

3. POLICY: It is VHA policy that each VHA facility must have at least one seamless transition facility POC, an alternate POC, and a facility OIF-OEF Case Manager to assist in the transition of returning combat veterans.

4. ACTION

a. **Veterans Integrated Services Network (VISN) Director.** Each VISN Director is responsible for designating a POC within the VISN to provide guidance to facility POCs and Case Managers.

b. **VISN POC.** Each VISN POC oversees the seamless transition of care and ensures that each facility in the VISN has selected a primary and alternate facility POC. Other responsibilities include:

(1) Ensuring that each facility in the VISN has made arrangements to assign an OIF-OEF Case Manager to each OIF and/or OEF service member or veteran being treated.

(2) Providing guidance and support to Facility POCs and OIF-OEF Case Managers, including ensuring they have adequate resources

(3) Notifying the VA Office of Seamless Transition (10AT), as soon as possible, of any changes in VISN POCs, facility POCs, OIF-OEF Case Managers, or VA-DOD Social Work Liaison. Maintaining an accurate POC Case Manager list is essential; the master list is updated weekly by the VA Office of Seamless Transition

(4) Serving as the clearinghouse for questions and problems related to the transfer of care and the provision of care to returning combat veterans and active duty personnel who have served in combat theaters in support of OIF and OEF.

(5) Having regular communication with facility POCs to troubleshoot barriers to services, to identify areas for improvement, and to identify best practices. ***NOTE:*** *Conference calls and e-mail groups are ideal for this communication.*

c. **Facility Director.** The facility Director is responsible for ensuring:

(1) Active duty service members needing urgent or emergent medical care receive the necessary care. Authorization and administrative issues need to be addressed, however without causing delay in care. ***NOTE:*** *The service member's MTF needs to be contacted as soon as possible to notify them of the care provided.*

(a) When being requested by an active duty service member to provide other than urgent or emergent treatment, authorization from the MTF, the service point of contact (SPOC), or the regional TRICARE contractor must be obtained prior to treatment. If the active duty service member lacks an authorization for routine care, appropriate staff must contact the appropriate MTF, the regional TRICARE Contractor or the SPOC to assist in obtaining the authorization. If the MTF, or TRICARE Contractor declines to provide an authorization, VA is unable to provide treatment. Staff must inform the active duty service member of the MTF or TRICARE Contractor determination and provide information to assist the service member in seeking treatment at the appropriate site of care (see VHA Directive 2005-045, Treatment of Active Duty Service Members in VA Health Care Facilities, for further details). ***NOTE****: Fee Basis is not to be used. Active duty service members can receive care outside the VA via TRICARE or authorization from their MTF. Care provided outside VA is to be coordinated with local MTF or TRICARE Service Center.*

(b) Active duty service members are the responsibility of the military. At any time, the military may request that VA transfer an active duty service member to a military hospital. VA's role is to be supportive to the military. The request to transfer a patient needs to be honored as soon as the patient is medically stable for transfer. If there is medical information that needs to be conveyed to the staff at the military facility, the facility clinicians or the facility POCs are to contact the staff at the receiving facility to communicate the necessary information. In addition, copies of the medical record need to be sent with the patient.

(2) That the facility POC is contacted immediately if an OIF and or OEF service member on convalescent leave seeks care from a VHA facility without being referred by an MTF or TRICARE. If the service member is seeking care for an emergent or urgent health care need, VHA will provide this care. If the service member is seeking care for a routine health care need, the Facility POC must obtain DOD or TRICARE authorization.

(3) A seamless transition facility POC and an alternate facility POC are designated. The role of these POCs is critical to the successful transfer of care from the MTF to VHA. VHA has standardized many of the functions of the facility POCs to ensure that the care of all returning combat veterans is transferred seamlessly from and to VHA. Facility POCs are responsible for coordinating all transfer arrangements at the receiving facility for all patient care referrals received from MTFs.

(4) Each returning combat veteran seeking treatment at a VA facility is assigned a facility OIF-OEF Case Manager, who must be either a social worker or nurse. This includes both inpatients and outpatients.

(5) Dedicated staff are assigned to the facility POC and facility OIF-OEF Case Manager roles. The responsibilities of these positions have grown since the inception of the seamless transition program precipitating the need to ensure that dedicated staff are assigned to the roles rather than having current staff perform the functions as a collateral duty.

(a) An adequate number of facility POCs and facility OIF-OEF Case Managers are to be designated based on the workload. Although there is not a prescribed ratio of facility POCs or

OIF-OEF Case Managers to patients, the number of OIF and OEF service members returning to that facility's catchment area and the number seeking health care at the facility need to be reviewed in order to ensure that adequate personnel are assigned to perform the duties. ***NOTE:*** *Case Managers at the Polytrauma Centers need to be assigned no more than six OIF and or OEF patients at any given time.*

(6) Facilities located close to MTFs, who have assigned social workers to serve as VA-DOD Social Work Liaisons for seamless transition, need to be closely monitored. If the workload warrants more than one full-time Liaison, a second Liaison needs to be assigned.

d. **VA-DOD Social Work Liaison.** The primary role of the VA-DOD Social Work Liaison is to ensure the transfer of health care, both inpatient and outpatient, from the MTF to the appropriate VHA facility. The VA-DOD Social Work Liaisons are stationed at the following eight MTFs: Walter Reed Army Medical Center, National Naval Medical Center, Brooke Army Medical Center, Eisenhower Army Medical Center, Evans Army Medical Center, Madigan Army Medical Center, Darnell Army Medical Center, and Naval Hospital Camp Pendleton. The responsibilities of the VA-DOD Social Work Liaison include:

(1) Working closely with the MTF treatment team to provide ongoing consultation regarding complex discharge planning issues, VHA health care benefits, resources, and facilities.

(2) Developing relationships and collaborating with the MTF social workers, case managers, managed care staff, and discharge planners to identify patients ready for discharge to VHA, and to obtain clear referral information and authorization for VHA to treat those still on active duty. This referral needs to:

(a) Including the MTF Medical Records, VA Referral Form, Admission Sheet, and Clinical Orders, or other authorization for VHA to provide services and bill TRICARE or other appropriate entity such as through a VA-DOD Sharing Agreement.

(b) Clearly identifying the patient's health care and psychosocial needs and requests for VHA health care services to ensure that Clinical Orders, or authorizations, specifying which services are authorized for VHA to provide are completed prior to the transfer of any patients to VHA facilities.

(3) Meeting with the service member and/or family to provide education and an overview of VHA health benefits and resources to address current medical issues identified as part of the service member's treatment plan. In collaboration with the MTF treatment team, the liaison must assess the patient and or family's psychosocial situation, their ability to comprehend and comply with VA treatment plan, and any special needs of the patient and/or family that may impact reaching optimal psychosocial functioning. ***NOTE:*** *Regular onsite collaboration and coordination is crucial to provide effective consultative services with the referral, linkage, education, and assessment functions. The provision of direct services may be necessary to enhance the communication and relationship with service members and their families.*

(4) Coordinating with the liaison's home facility enrollment coordinator to initially register active duty OIF-OEF service members or enroll OIF-OEF veterans at their facility utilizing the referral information. Getting the service members registered and in the computer system eases transfer of care to the VHA treatment facility.

(5) Collaborating with MTF social workers and case managers in identifying the VHA facility where care will be transferred and an accepting physician at that facility. To ensure ease of registration or enrollment procedures, information must be transmitted via PDX or Network Health Exchange (NHE) from the liaison's facility to the identified receiving VHA facility.

(6) Identifying and communicating with the facility POC at the receiving VHA facility and initiating referrals and linkages for transfers of care.

(7) Documenting all liaison activity in the Computerized Patient Record System (CPRS).

(8) Maintaining contact with the VHA facility POC and with MTF staff, coordinating the transfer of care upon discharge from the MTF; and assisting in identifying and obtaining additional information needed from the MTF staff to optimize the transfer of care.

(9) Providing patient level referral and outcome information on all transfers of care from the MTF to the VHA Social Work Program Manager to VA Central Office, Office of Seamless Transition, on a monthly basis through use of a spreadsheet (see Att. B), and inputting summary information into an automated intranet workload report on a weekly basis.

e. **VHA Facility POC.** The principal role of the VHA facility POC is to receive and expedite referrals and transfers of care from the VHA Social Work Liaison and to ensure that the appropriate linkage is made for the requested clinical follow-up services. ***NOTE:*** *Given the importance of this patient population, significant efforts must be made to expedite the transfer of care and provision of the VHA health care services identified.* Responsibilities of the facility POC are:

(1) Confirming that OIF-OEF service members are registered and OIF-OEF veterans are enrolled at the treating VHA facility and arranging for assignment to the appropriate health care provider, based on the Clinical Orders or authorization received from the MTF.

(2) Coordinating initial transfer of care activities (i.e., arranging for an inpatient bed; ensuring that outpatient appointments have been made, etc.) and ensuring the continuing provision of necessary Durable Medical Equipment, prosthetic devices, supplies, etc.

(3) Documenting all activity in CPRS.

(4) Ensuring the receipt of copies of the military medical record from the referring MTF and coordinating the completion of all necessary paperwork for the transfer of care, including application for VHA medical benefits.

(5) Serving as the primary facility liaison with the referring VA-DOD Social Work Liaison on all information and coordination of activities. Serving as the initial POC to the active duty members, veterans, and their families during the initial entry into the VHA health care facility (i.e., meeting patients and families on first visit)

(6) Alerting the facility OIF-OEF Case Manager of the impending transfer of care of all OIF-OEF service members and veterans.

(7) Immediately alerting the appropriate VBA Case Manager of the service member's transfer.

(8) Working with local military units, VBA Regional Offices, and Vet Centers staff in providing outreach to service members returning from Iraq and Afghanistan.

f. **VHA Facility OIF-OEF Case Manager**

(1) The principal role of the facility OIF-OEF Case Manager is to provide ongoing case management services to returning OIF and OEF service members, veterans, and their families over the course of time VHA health care services are being provided. ***NOTE:*** *While this Directive pertains primarily to the patients transferred from an MTF, Case Management services need to be provided to OIF and/or OEF veterans who are enrolled and receiving VA health care services. This includes veterans who may not have been transferred through the Seamless Transition process from an MTF to a VA facility and are seeking healthcare on an outpatient basis following discharge from the Military. Though these patients may not require intensive case management, each OIF and/or OEF patient must have an initial assessment by a case manager to identify and assist with immediate needs. A facility OIF-OEF Case Manager must also be accessible to the patient should additional needs arise in the future.*

(2) Other responsibilities include:

(a) Making initial contact with the OIF and/or OEF service member prior to transfer of health care from the MTF to provide the facility OIF-OEF Case Manager's name and phone number and to explain the role of a facility OIF-OEF Case Manager.

(b) Making initial contact with the OIF or OEF service member's immediate family to determine whether any family members will accompany the service member to the VHA facility. If family members accompany the service member, or visit during an inpatient stay, the facility OIF-OEF Case Manager assists in arranging lodging in a VHA Fisher House or in the local community. The facility OIF-OEF Case Manager determines whether the family members require air transportation, and if so, assists them in applying for free airline ticket vouchers through Operation Hero Miles.

(c) Serving as the ongoing contact person for the family and for the MTF staff. This involves regular communication with the family.

(d) Working closely with the service member's interdisciplinary treatment (IDT) team to ensure good communication and treatment planning.

(e) Facilitating, when indicated, communications between the VHA provider and the service member at the MTF to discuss transfer of medical care. The facility OIF-OEF Case Manager serves as the point of contact when MTF providers wish to speak to the VHA provider regarding the care being provided.

(f) Communicating and collaborating closely with the VBA Case Manager and assisting VBA in making contact with the service member.

(g) Contacting the referring MTF to obtain new clinical orders or authorization for additional care or services if additional health services beyond those specified in the original referral from the MTF are required for active duty service members.

(h) Contacting the provider at the referring MTF, if the service member requires care or services not provided by the VHA facility, to obtain authorization for referral to another VHA facility or to a community agency. Once authorization is provided, the facility OIF-OEF Case Manager makes referrals to community agencies for services not provided by VA, and, in conjunction with TRICARE or the MTF, coordinates all care and services provided to the service member by VA and non-VA agencies from the initial point of contact until the service member no longer requires services.

(i) Continuing to follow veterans who are transferred for treatment at contracted health care facilities nearby. Follow-up includes, but is not be limited to:

1. Communicating and or collaborating, on a regular basis, with the staff and or treatment teams at the contracted facility, VA (both VHA and VBA), and the home MTF.

2. Ongoing communication and coordination of VHA services with the veteran and the veteran's family regarding VA benefits, health care coordination, and education.

(j) Identifying mental health treatment needs and readjustment counseling needs. If such needs are identified, the facility OIF-OEF Case Manager contacts the referring MTF to obtain new Clinical Orders, or authorization, for the additional care or services. Once authorization is provided, the case manager makes referrals, as appropriate, to the VHA facility Mental Health Program and/or to the local Vet Center.

(k) Communicating regularly with the MTF provider and case manager or social worker who referred the service member. If the service member has started the military disability process in order to obtain a medical discharge or medical retirement from active duty, the facility OIF-OEF Case Manager is responsible for:

1. Providing information about the VHA treatment services being provided to the MTF Physical Evaluation Board (PEB) staff on a regular basis, and

2. Ensuring coordination with the VBA Case Manager.

(l) Actively participating in discharge planning, if the service member is receiving inpatient care at the VHA facility, involving the service member and family and keeping the MTF updated.

(m) Documenting all activity in CPRS.

5. REFERENCES

a. VHA Directive 2005-020, Determining Combat Veteran Eligibility. http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1270

b. VHA Directive 2003-061, Combat Veteran Intake Processing And Software Implementation. http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=289

c. VHA Directive 2002-049, Combat Veterans Are Eligible For Medical Services For 2-Years After Separation From Military Service Notwithstanding Lack Of Evidence For Service Connection. http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=197

d. VHA Directive 2005-045, Treatment of Active Duty Service Members in VA Health Care Facilities. http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1325

6. FOLLOW-UP RESPONSIBILITY: The Director, Seamless Transition (10AT) is responsible for the contents of this Directive. Questions are to be referred to (904) 287-2082.

7. RESCISSION: None. This VHA Directive expires September 30, 2007.

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Under Secretary for Health

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ATTACHMENT A

MILITARY TREATMENT FACILITIES WITH DEPARTMENT OF VETERANS AFFAIRS (VA) - DEPARTMENT OF DEFENSE (DOD) SOCIAL WORK LIAISONS STATIONED ON-SITE

1. Walter Reed Army Medical Center, Washington, DC.
2. National Naval Medical Center, Bethesda, MD.
3. Brooke Army Medical Center, San Antonio, TX.
4. Darnell Army Community Hospital, Ft. Hood, TX.
5. Madigan Army Medical Center, Tacoma, WA.
6. Eisenhower Army Medical Center, Augusta, GA.
7. Evans Army Medical Center, Ft. Carson, CO.
8. Naval Hospital, Camp Pendleton, CA.

NOTE: *The Social Work Program Manager for the Office of Seamless Transition serves as the Veterans Health Administration (VHA) Liaison for the remaining MTFs.*

ATTACHMENT B

SAMPLE OF DEPARTMENT OF VETERANS AFFAIRS (VA) - DEPARTMENT OF DEFENSE (DOD) SOCIAL WORK LIAISON REFERRAL TRACKING SPREADSHEET

Sample VA-DOD
Liaisons Workload Ca

#	Name of MTF	Rank at Time of Referral (Rank or Unknown)	Last Name	First Name	Middle Name	Suffix	Full SSN	OIF/OEF/ Non	Date of Birth	Gender (M/F)	Home Phone	Cell Phone

Branch of Service (Army/Marines/ Navy/ AF/CG)	Status - AD/NG/ RES	VA Employee (Yes / No)	Military Class of Injury - Battle Injury (BI) Non-Battle Injury (NBI) or Disease (Dis)	Veteran Service Rep VBA Referral/ Involvement (Yes/No)	Date Referral to VHA/DoD Liaison Received	Date of First Pt/Fam Contact w/Liaison	Name of VHA Facility Referred To	Inpatient or Outpatient Transfer (I or O)	Enrollment Status (Yes/No)

VHA OIF/OEF POC Communication (Yes/No)	Name of VHA Point of Contact	Type of Care Coordinated (TBI/SCI/VIST/ Amputee/MH/PC/ Other)	Status of Referral (Pending or Date Referral Closed)	VHA Comments